Noemi A. Bolton, MSSN, MSW, LCSW

Psychotherapy for Individuals, Couples, Families & Groups

24 Mine Street, Suite 2D, Flemington, NJ 08822 | Web: www.noemibolton.com | Phone: (908) 246-7489 | Fax: (908) 806-2379

CLIENT INTAKE FORM

Please complete this form for office records and bring it with you to our first appointment.
Any information you provide in this form is kept confidential.

Last Name:	First Name:		Middle Initial:
Date of Birth: (mm/dd/yyyy)	Age:	Sex: ☐ Male ☐ Female	I identify my gender as: ☐ Male ☐ Female ☐ Other:_____
Marital Status: (Select One.) ☐ Never Married ☐ Domestic Partnership ☐ Married; for how many years? _____ ☐ Separated ☐ Divorced ☐ Widowed			
Ethnicity: (Select One) ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	Race: (Select One)* ☐ White ☐ Black ☐ Native American/Eskimo/ Aleutian ☐ Asian/Pacific Islander ☐ Other		Social Security Number:
If under age 18, please enter Parent/Guardian Name below:			
Guardian Last Name:	Guardian First Name:		Guardian Middle Initial:

Home Street Address:	City:	State:	Zip Code:
Mailing Address (if different from Home Address):	City:	State:	Zip Code:

Home Phone No.:	Cell Phone No.:	Work Phone No.:	eMail Address:
May we leave a message at home? ☐ Yes ☐ No	May we leave a message on your cell? ☐ Yes ☐ No	May we attempt to reach you at work if needed? ☐ Yes ☐ No	*May we email you? ☐ Yes ☐ No

Please Note: eMail correspondence is not considered a confidential medium of communication.

Emergency Contact or Next of Kin Name:	Emergency Contact or Next of Kin Phone No.:	Emergency Contact Relationship to you:
Spouse or Domestic Partner's name:	Spouse or Partner's Home Phone No.:	Spouse or Partner's Cell Phone No.:

If you have children, please list names and ages:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Who referred you to this office? ☐ Family ☐ Friend ☐ Doctor ☐ Other	Name of individual who referred you:	If not referred, how did you find this office? ☐ Brochure ☐ Online ☐ Card ☐ Other:_____

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GENERAL HEALTH & MENTAL HEALTH INFORMATION

CURRENT HEALTH CONCERNS

1. How would you rate your current physical health? (Please select.)

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

   Please list any specific health problems you are currently experiencing:

2. Do you exercise? ☐ Yes ☐ No

   What types of exercise do you participate in, and how many times per week?

3. How would you rate your current sleeping habits? (Please select.)

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

   Please list any specific sleep problems you are currently experiencing:

4. How would you rate your current appetite and/or eating habits? (Please select.)

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

   Please list any specific appetite or eating problems you are currently experiencing:

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

   If yes, for approximately how long?

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

   If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? ☐ Yes ☐ No

   If yes, please describe:

8. Have you had suicidal thoughts recently? ☐ Yes ☐ No If yes, how often? ☐ Frequently ☐ Occasionally ☐ Rarely

9. Have you had suicidal thoughts in the past? ☐ Yes ☐ No If yes, how often? ☐ Frequently ☐ Occasionally ☐ Rarely

10. Have you experienced any significant life changes or stressful events recently? ☐ Yes ☐ No
    If yes, please explain.

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CURRENT HEALTH CONCERNS

11. Do you drink alcohol more than once a week? ☐ Yes ☐ No

    If yes, approximately how often?

12. Do you engage in recreational drug use? ☐ Yes ☐ No

    If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

13. Are you currently in a romantic relationship? ☐ Yes ☐ No

    If yes, for how long?

    On a scale of 1 (Poor) to 10 (Fantastic!), how would you rate this relationship? (Please circle.) ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

14. Are you experiencing any sexual concerns or problems? ☐ Yes ☐ No

    If yes, please briefly describe:

15. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

    If yes, who is your previous therapist/practitioner? (Please provide name.) _____

    Briefly describe what they treated you for:

16. Are you currently taking any prescription medication? ☐ Yes ☐ No

    If yes, please list the prescription medication(s):

17. Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

    If yes, who prescribed it? (Please provide name.) _____

    If yes, please list psychiatric prescription medication(s): (Provide dates.)

Please clearly check ☒ the appropriate boxes to rate the severity *ONLY for any other symptoms you are experiencing*.

Symptoms	Low	Moderate	Severe
Elevated Mood (extreme)	☐	☐	☐
Gambling Addiction	☐	☐	☐
Inability to Concentrate/Think	☐	☐	☐
Inability to Function Day to Day	☐	☐	☐
Inability to Make Decisions	☐	☐	☐
Irritability/Anger/Temper Problems	☐	☐	☐
Lack of Energy or Extreme Fatigue	☐	☐	☐
Memory Problems	☐	☐	☐
Pornography Addiction	☐	☐	☐
Reasoning/Judgment Problems	☐	☐	☐

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FAMILY MENTAL HEALTH HISTORY

In the section below, please clearly check ☒ the appropriate boxes to indicate if there is a family history of any of the following health issues. If yes, please indicate the family member's relationship to you in the space provided (e.g., father, mother, sibling, grandparent, cousin, etc.)

Health Issue	Please select Yes or No	List Applicable Family Member(s)
Alcohol/Substance Abuse	☐ Yes ☐ No	
ADHD/ADD	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Asperger's/Autism	☐ Yes ☐ No	
Bipolar Disorder	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Drugs/Substance Abuse	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Epilepsy/Seizures	☐ Yes ☐ No	
Learning Disability	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Panic attacks	☐ Yes ☐ No	
Psychosis	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	

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ADDITIONAL INFORMATION

EMPLOYER INFORMATION			
Employer Name:			
Street Address:			
City:	State:	Zip Code:	Business Phone No.:
Occupation:	Do you work?: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Returning to Work ☐ Unemployed		
If yes, do you enjoy your job? ☐ Yes ☐ No	How long have you been on this job?		
Is there anything stressful about your job? ☐ Yes ☐ No If yes, please describe.			
Do you have special expertise or training? ☐ Yes ☐ No If yes, please describe.			
MILITARY BACKGROUND			
Did you serve in the military? ☐ Yes ☐ No	If yes, what was your job in the military?		
Did you experience traumatic events while deployed? ☐ Yes ☐ No If yes, briefly describe.	How did you exit the military?		
Have you experienced any symptoms of PTSD? ☐ Yes ☐ No If yes, briefly describe.			
INSURANCE INFORMATION			
Insurance Company Name:	Primary Insured's Name:	Primary Insured's Date of Birth:	Primary Insured's Social Security Number:
Street Address:			
City:	State:	Zip Code:	Insurance Company Phone No.:
Insurance Plan or Program Name	Insured's Insurance ID No.:		Insurance Policy Group No.:
PRIMARY CARE PHYSICIAN INFORMATION			
Physician's Name:			
Street Address:			
City:	State:	Zip Code:	Physician's Phone No.:
When was the most recent visit to your doctor (approximate)? What was the reason for the visit?	List any major illnesses or operations you have had; provide approximate dates.		

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HIGH SCHOOL INFORMATION					
High School Name:					
Street Address:					
City:	State:	Zip Code:	Years attended:	Did you graduate? ☐ Yes ☐ No	
COLLEGE INFORMATION					
College Name:					
Street Address:					
City:	State:	Zip Code:	Years attended:	Major area of study:	Did you graduate? ☐ Yes ☐ No

OTHER INFORMATION

1. Do you consider yourself religious or spiritual? ☐ Yes ☐ No

   If yes, please indicate your faith or religious affiliation:

2. What sort of hobbies or things do you enjoy doing in your free time?

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish during your time in therapy?

To the best of my knowledge, the preceding information provided is accurate and complete.

Client Signature _____ **Date of Signature** _____

Client's Parent/Guardian Signature (if under age 18) _____ **Date of Signature** _____

If Guardian, Relationship to Client _____